

Correspondence

Ultrasonographic Diagnosis of Abdominal Aneurysm by Emergency Department Physicians

TO THE EDITOR: Ultrasonography offers untapped potential to improve the practice of emergency medicine. Painless, noninvasive, and without inherent risks or side effects, ultrasonography is a powerful and dynamic tool used for diagnosis and to facilitate invasive procedures. Currently used chiefly by radiologists, cardiologists, obstetricians, gynecologists, and vascular surgeons, it is well suited for emergency physicians as well.^{1,2}

Over the next three to five years, it is anticipated that the diagnostic use of ultrasonography, as done by emergency physicians, will be the standard of care. The American College of Emergency Physicians has adopted a position statement supporting the immediate availability of emergency department ultrasonograms on a 24-hour-a-day basis. Many emergency medicine residency programs are now including ultrasound training in their curricula.

Unfortunately, many emergency department physicians are meeting resistance to the introduction of ultrasonography into their personal scope of practice. Radiologists, in particular, have shown a reluctance to endorse nonradiologists independently performing or interpreting ultrasonograms in the emergency department.

One key issue is the urgency of the examination. Emergency physicians think that, for certain patients, a 30- to 45-minute delay while awaiting the arrival of an on-call technician is unacceptable. Included in this group would be patients with an abdominal aortic aneurysm, a ruptured ectopic pregnancy, pericardial effusion or tamponade, blunt abdominal trauma with possible intraperitoneal blood, or trauma in a pregnant patient (to evaluate the health of the fetus). Ultrasonography can also be instrumental in directing emergency therapy and intervention.

Another point of contention is the competency of the examiner, particularly if the sonographer is an emergency physician.³ Courses are available, however, to teach limited emergency ultrasonography that, when combined with practical experience, would provide the necessary competency.

A final concern is the cost or, more specifically, the reimbursement for the examination, perpetuating the never-ending turf battle for shrinking dollars.

Despite these obstacles, if the primary goal of emergency physicians is to deliver the best emergency care, they should consider using ultrasonography to manage patients with immediate and life-threatening conditions, requiring a collaborative effort by the departments of emergency medicine, radiology, obstetrics and gynecology, and cardiology.

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Medical Paternalism Revisited

TO THE EDITOR: I am writing about the article by Dr Robert D. Orr regarding his confrontation with his own "paternalism" in the March 1995 issue.¹ In my opinion, Mrs Pulaski may have lacked decision-making capacity. She was in a state of crisis—embarrassed, overwhelmed, and possibly disoriented. She did not seem to fully appreciate the gravity of her situation. I wonder if she could have explained what her medical problem was, the possible consequences of refusing treatment, and her reason for refusal.² Additionally, treatment refusal did not fit with her previous pattern of medical compliance.

As a consultation psychiatrist and a member of our hospital bioethics committee, I am frequently confronted with the nondemented, nonpsychotic patient who may lack the capacity to make medical decisions because of a functional state. Depression, denial, and lack of maturity all can impair a patient's ability to give informed consent.^{3,4} More discussion of this topic would be welcome. I confess that at times I, too, am a closet paternalist.

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TO THE EDITOR: Robert D. Orr, MD, is to be commended for allowing the appeal of a spunky old lady to generate a caring that overcame the casuistic catechism of contemporary ethical analysis in medicine.¹ In saying to Mrs Pulaski, "Put your hand on my shoulder," and helping her onto the stretcher, he demonstrated the caring that almost 70 years ago, Peabody lucidly described as at the heart of the care of the patient.²

I suggest that the root of the predicament in which Dr Orr found himself, a predicament in which most current ethical discussions leave the physician who is facing a "real live patient," lies in an analysis of the clinical situation in terms of the stance of each individual, patient